effect for the provider. Upon receipt of a valid interim rate request subsequent to June 30, 1984, the AHCA Office of Medicaid must determine whether additional information is needed from the provider and request such information within 30 days. Upon receipt of the complete, legible additional information as requested, the AHCA Office of Medicaid must approve or disapprove the interim rate within 60 days. If the Office of Medicaid does not make such determination within the 60 days, the interim rate request shall be deemed approved.

5. Interim Rate Settlement.

Overpayment as a result of the difference between the approved budgeted interim rate and actual costs of the budgeted item shall be refunded to AHCA. Under-payment as a result of the difference between the budgeted interim rate and actual allowable costs shall be refunded to the provider. After the interim rate is settled, a provider's cost basis shall be restricted to the same limits as those of a new provider per Section I. below.

6. The right to request interim rates shall not be granted for fiscal periods that have ended.

H. For a new provider in a facility with greater than six beds, the interim cost per diems for each reimbursement class shall be the budgeted component cost rates approved by AHCA. These initial cost estimates shall be limited as follows:

A. Property Costs:

Must be approved by the AHCA Office of Medicaid and shall not be in excess of the limitations established in Section III. of this plan.

B. Operating Costs:

Shall not exceed the 90th percentile of per resident day costs of all currently participating ICF/MR-DD providers that currently have prospective rates.

C. Resident Care Costs:

Shall not exceed the highest per resident day cost for the respective reimbursement class of any other currently participating provider having a prospective rate.

I. For a new provider in a facility with greater than six beds, AHCA shall establish the cost basis for calculation of prospective rates using the first acceptable historical cost report covering at least a 12- month period submitted by the provider. Overpayment as a result of the difference between the approved budgeted interim rate and actual allowable costs of the budgeted item shall be refunded to AHCA. Underpayment as a result of the difference between the budgeted interim rate and actual allowable costs shall be refunded to the provider. The basis for calculating prospective rates shall be the first year settled cost report. Basis shall be set at 100 percent of the total allowable costs as determined by Medicaid and the Developmental Services Program Office.

J. Base Costs:

The initial base costs for each provider
shall be allowable costs documented by the cost report used
to establish the rate being set. For new providers entering the Medicaid program the
initial base costs shall be established in accordance with Section IV.I. of this plan. Prospective rates calculated using unadited costs shall be retroactively adjusted when audit results become available.

K. Aggregate test comparing Medicaid to Medicare according to 42 CFR 447.253(6) , the Medicaid agency's estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for long-term care facility services than the amount that would be paid for the services under the Medicare principles of reimbursement.

At any rate-setting period, if the aggregate reimbursement to be paid is higher than would be paid under Medicare principles, property cost shall be reduced or eliminated as necessary to meet the aggregate test.

V. Methodology

A. Prospective rate-setting method for rate semesters beginning on or after July 1, 1991.

1. For rate semesters beginning on April 1 of a given year, the prospective rates shall be set using the most current acceptable cost report on file with AHCA as of February 1 of that year. For rate semesters beginning on October 1 of a given year, the prospective rates will be set using the most current acceptable cost report on file with AHCA as of August 1 of that year. For the rate semester July 1, 1991 through March 31, 1992, the same cost reports used in setting April 1, 1991, rates shall be used. There shall not be a rate semester for October 1, 1991.

2. Review and adjust the provider's current cost report on file to reflect the results of desk or on-site audits, if available.

3. Determine total allowable cost by reimbursement class for property cost, resident care cost, and operating cost. See the Definitions section of this plan for the definitions of allowable costs for each of the cost components. Costs shall be allocated to each reimbursement class by the methodology shown in Appendix A.

4. Calculate per diems for each of the three cost components for the two reimbursement classes by dividing the component's cost by the appropriate number of resident days.

5. The new base per diem for property shall be the per diem established in step 4 above.

6. Using the appropriate current per diem for resident care and operating costs from Step 4 above, calculate the prospective operating and resident care per diems for the new rate semester by multiplying each of the base per diems by the fraction:

   Simple average of the Florida ICF/MR-DD monthly cost inflation indices for the prospective rate semester divided by the simple average of the Florida ICF/MR-DD monthly cost inflation indices for the cost report period used to calculate current base per diems. For rates effective July 1, 1991, the prospective rate semester used in calculating the above fraction shall be the period July 1, 1991 through March 31, 1992.

7. Establish the total prospective per diem for each reimbursement class as the sum of the appropriate operating and resident care per diems resulting from Step 6 plus the current approved per diem for property, from Step5.

VI. Payment Assurance

The state shall pay each provider for services provided in accordance with the requirements of the Florida Title XIX state plan and applicable state or federal rules and regulations. The payment amount shall be determined for each provider according to the standards and methods set forth in this Florida Title XIX ICF/MR-DD Reimbursement Plan for Publicly Owned and Publicly Operated Facilities

VII. Provider Participation

This plan is designed to assure adequate participation of Publicly Owned and Publicly Operated ICF/MR-DD providers in the Medicaid program, the availability of high-quality services for recipients, and for services which are comparable to those available to the general public.

VIII. Payment in Full

Payments made to any provider participating in the Florida Medicaid program who knowingly and willfully charges, for any service provided to the resident under the state plan, money or other consideration in excess of the rates established by the state plan, or

charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under the State plan approved under this title, any gift, money, donation or other consideration, other than a charitable, religious or philanthropic contribution from an organization or from a person unrelated to the resident: as a condition of admitting a resident to a Publicly Owned and Publicly Operated ICF/MR-DD facility; or as a requirement for the resident's continued stay in such a facility, when the cost of the services provided therein is paid for, in whole or in part, under the state plan, shall be construed to be supplementation of the state's payment for services. Payments made as a condition of admitting a resident or as a requirement for continued stay in a facility shall be deemed to be payments to meet the cost of care of the Medicaid resident and shall be deemed to be out of compliance with 42 CFR 447.15 .

IX. Definitions

Acceptable Cost Report: A completed, legible cost report that contains all relevant schedules, worksheets and supporting documents in accordance with cost reporting instructions.

AHCA: Agency for Health Care Administration, also known as the agency.

CMS PUB.15-1: also known as the Provider Reimbursement Manual, published by the Department of Health and Human Services, Centers for Medicare and Medicaid Services.

DCF: Department of Children and Family Services

ICF/MR-DD Operating Costs: Those costs not directly related to resident care or property costs. Operating costs include administrative, plant operation, laundry and housekeeping costs. ICF/MR-DD Resident Care Costs: Those costs directly attributed to nursing services, dietary costs, and other costs directly related to resident care such as activity costs, social services, and all medically-ordered therapies.

ICF/MR-DD Property Costs: Those costs related to the ownership or leasing of an ICF/MR-DD. Such costs may include property taxes, insurance, interest and depreciation, or rent.

Title XVIII: Health Insurance for the Aged, Blind or Disabled (Medicare) as provided for in the Social Security Act (42 U.S.C. 1395-1395pp).

Title XIX: Grants to States for Medical Assistance Programs (Medicaid) as provided for in the Social Security Act (42 U.S.C. 1396-1396i)

Medicaid Interim Reimbursement Rate: A reimbursement rate or a portion of an overall reimbursement rate that is calculated from budgeted cost data.

APPENDIX A

Provider Number FY: 09/30/84

Provider Name Audit Status Unaudited

Address

	COL C	COL A Resid./ Inst.	COL B Non-amb./ Medical	TOTAL
A.	Alloc of Exp (Excl B&C)			
1.	Resident Days	02461	8325	10786
2.	OPER. EXPENSE COMP			
a.	Administration	-	-	120482
b.	Plant Operation	-	-	45060
c.	Laundry	-	-	15265
d.	Housekeeping	-	-	29090
e.	Oper. Exp. Comp and Per Diem	19.460	19.460	209897
3.	Resident Care Expense			
a.	Dietary	-	-	74861
b.	Other -	-	34188	
c.	Nursing	-	-	86018
d.	Res. Care Exp. and Per Diem	18.0852	18.0852	19.5067
4.	PROP. EXP. COMP. AND PER DIEM	8.605	8.605	92812
5.	ROE/UA COMP & PER DIEM	6.604	6.604	71236
B.	DIRECT CARE EXPENSE			
1.	Staffing	.5	1.	-
2.	Total Staffing Required	1230.5	8325	95555
3.	Staffing Percent	12.877%	87.123	100%
4.	Alloc. of Direct Care	39263.97	26542.03	304906
5.	Dir. Care Exp. Per Diem	15.945	31.9090	
C.	ADDITIONAL SERVICES EXPENSE			
1.	Medicaid Patient Days	2461	8275	10736
2.	Add. Ser. (Sch.AM-6)	36780	69380	106160
3.	Add. Ser. Exp. Per Diem	14.951	8.3839	
D.	MEDICAID PER DIEM COST			
1.	Operating Component	19.460	19.460	209897
2.	Resident Care Component	48.985	58.378	606133
3.	Property Cost Component	8.605	8.605	92812
	Subtotal (Schedule BM)	.-	.-	-
4.	ROE/USE ALLOW Comp.	6.604	6.604	71236
5.	TOTAL PER DIEM COST	83.654	93.047	980078

APPENDIX B

CALCULATION OF THE
FLORIDA ICF/MR-DD COST INFLATION INDEX

1. Weights.

Percentage weights for cost components shall be based on cost reports filed for fiscal years ending in 1983. These percentage weights are:

Salaries and Benefits	65.66%
Dietary	4.94%
All Other	29.40%
	100.00%

2. Inflation index for each component

An inflation index for each of these components is developed from the Data Resources, Inc. (DRI) Skilled Nursing Facility Market Basket of Routine Services Costs inflation indices as follows:

COMPONENT	DRI INDEX
Salaries and Benefits with Employee Benefits	Wages and Salaries, combined
Dietary	Food
All Others with other expenses	Fuel and Utilities, combined

The DRI indices that are combined are merged by summing the products of each index times the ratio of the respective DRI budget share to the total share represented by the combined indices.

Example: Calculation of the Salaries and Benefits combined index for the third quarter of 1984 using Health Care Costs, Third Quarter 1983 Series, p. 15:

DRI Wages and Salaries index = 1.043; Budget Share = .602

DRI Employee Benefits index = 1.073; Budget share = .084

Weighted Combination (Salaries and Benefits) =
(1.043 x (.602/(.602 + .084))) + (1.073 x (.084/
(.602 + .084))) = 1.047

3. Quarterly and monthly indices.

A weighted quarterly index is then constructed by summing the products of the weights and quarterly component indices. This quarterly composite index is used to obtain monthly indices called the Florida ICF/MR-DD Cost Inflation Index by averaging pairs of quarterly indices and interpolating between these averages as follows:

Quarter Midpoint Quarter	Index	Average Index	Corresponding Month
1984:1	1.029		
		1.032	March 31
184:2	1.035		
		1.042	June 30
1984:3	1.048		
		1.054	September 30
1984:4	1.059		

April 30 Index = (June 30 Index/March 31 Index)$^{1/3}$ x (March 31 Index)
= (1.042/1.032)1/3 x 1.032
= 1.035

May 30 Index = (June 30 Index/March 31 Index)$^{2/3}$ x (March 31 Index)
= (1.042/1.032)2/3 x 1.032
= 1.039

All other monthly indices can be calculated in a similar fashion.

4. Inflation Factors

The inflation factors used to set both target rates of inflation and prospective payment rates utilize 13 indices in order to recognize full inflation for a 12-month period. This is necessary because each index represents the relative level of costs at the end of the month, so that a complete 12-month inflation trend must start with the index as of the last day of the month prior to the 12-month period.
Example: Calculation of target rate of inflation factor for provider with a June 30 fiscal year end.

$$\text{1984 Target factor} = \frac{\text{average of inflation indices from June 1983 through June 1984}}{\text{average of inflation indices from June 1982 through June 1983}}$$

$$\frac{(.994 + .999 + 1.004 + 1.009 + 1.014 + 1.018 + 1.023 + 1.026 + 1.029 + 1.032 + 1.035 + 1.039 + 1.042)/13}{(.950 + .954 + .958 + .962 + .966 + 971 + .975 + .979 + .982 + .986 + .989 + .992 + .994)/13}$$

$$= \frac{1.020}{.974}$$

$$= 1.047$$

In the example above, the indices for June 30, 1982, .994, and June 30, 1983, .950 are taken to represent the relative level of costs on July 1, the beginning of the fiscal year, and the end of the fiscal year, respectively. Hence, in order to measure the change in the relative level of costs for a fiscal year ending June 30, the 13 indices are used to capture a complete 12-month period.

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